DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 1/16/11

PRINTED: 12/06/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445498	A. BUILDING _____ B. WING _____	12/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRISTOL NURSING HOME	261 NORTH STREET BRISTOL, TN 37625

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure a physician's order recommending psychiatric services to withdraw a medication was completed for one resident (#1) of twenty-two residents reviewed. The findings included: Resident #1 was admitted to the facility on December 27, 2007, and readmitted on October 13, 2010, with diagnoses including End-Stage Renal Disease, Depression, Senile Dementia, and Dementia with Behavioral Disturbance. Medical record review of a Physician's Order dated November 3, 2010, revealed "...recommend psych to withdraw Celexa..." Medical record review of the a Psychiatric Note dated November 12, 2010, revealed no evidence the Celexa was withdrawn as recommended by the physician. Medical record review of the Medication Administration Record (MAR) dated November 1, 2010, through November 30, 2010, revealed the Celexa was administered and was not withdrawn as recommended by the physician. Observation on November 29, 2010, at 1:40 p.m.,	F 281	The submission of the Plan of Correction does not constitute agreement on the part of Bristol Nursing Home that the deficiencies cited within the report represents deficient practices on the part of Bristol Nursing Home. This plan represents our ongoing pledge to provide quality care that is rendered in accordance with all regulatory requirements. **F 281 Services Provided Meet Professional Standards** **Corrective Action:** Celexa was discontinued for Resident #1 on 11/30/2010. **Identification:** Current residents have the potential to be affected. Currents residents will have a chart audit of physician orders and progress notes to ensure all recommendations are being addressed by 12/23/10 **Systematic Changes:** Licensed Nurses will be in serviced on reviewing physician orders and physician progress notes daily by ADON on 12/17/2010 & 12/20/10. Physician progress notes & physician orders will be audited weekly by charge nurses for 3 months & monitor weekly by ADON, MDS, & Unit Manager to ensure recommendations are addressed **QA/Monitoring:** Director of Nursing will review the audits completed by ADON, MDS, & Unit Manager with the Quality Assurance Committee (Administrator,	12/23/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mary Patricia Money — TITLE: Administrator — (X6) DATE: 12-16-10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/06/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445498	A. BUILDING _____ B. WING _____	12/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRISTOL NURSING HOME	261 NORTH STREET BRISTOL, TN 37625

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 1 and on November 30, 2010, at 10:35 a.m., in the resident's room, revealed the resident alert, responsive, and seated in a wheelchair. Interview with Director of Nursing on November 29, 2010, at 3:30 p.m., in the Conference Room, confirmed the facility failed to follow the Physician's Order recommending psych services to withdraw the Celexa.	F 281	Medical Director, Director of Nursing, Assistant Director if Nursing, Director of Social Services, Business Office Manager, Dietary Manager, Maintenance Director, Housekeeping Manager, and Human Resource Manager) monthly. Quality Assurance Committee will make recommendations to improve the review process and determine when compliance has been reached.	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure toenails were maintained at a comfortable length for one resident (#5) of twenty-two residents reviewed. The findings included: Resident #5 was admitted to the facility on April 20, 2007, with diagnoses including Failure to Thrive, Senile Dementia, Anxiety, and Depression. Medical record review of the Minimum Data Set dated September 10, 2010, revealed the resident had short and long term memory problems, required extensive assistance with decision making, and required total assistance with all activities of daily living.	F 312	**F 312 ADL Care Provided For Dependent Residents** 12/23/10 **Corrective Action:** Toenails of Resident # 5 were trimmed by licensed nurse on 12/2/2010. **Identification:** Current residents have the potential to be affected. Current residents' toenails will be assessed to ensure appropriate length is being maintained by 12/23/10. **Systematic Changes:** Licensed Nurses/CNAs will be in serviced by ADON on 12/17/2010 & 12/20/10 on observing toenail length and reporting any resident that may need podiatry intervention to DON or ADON. Residents will have toenails observed by CNAs & Charge nurses weekly to determine if podiatry consult is indicated. **QA/Monitoring:** Director of Nursing will review the results of the toenail observations & podiatry list completed by charge nurses/unit manager with the	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/06/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445498	A. BUILDING _____ B. WING _____	12/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRISTOL NURSING HOME	261 NORTH STREET BRISTOL, TN 37625

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 2 Observation on November 29, 2010, at 9:30 a.m., in the day room, revealed the resident seated in a Geri chair with a sock only on the left foot. Continued observation revealed the resident's toe nails were long and jagged extending approximately three-forth inches over the tip of the toe. Interview with the Licensed Practical Nurse (#1) on November 29, 2010, at 9:40 a.m., in the second floor day room, confirmed the toenails were long, jagged, and needed to be trimmed.	F 312	Quality Assurance Committee (Administrator, Medical Director, Director of Nursing, Assistant Director if Nursing, Director of Social Services, Business Office Manager, Dietary Manager, Maintenance Director, Housekeeping Manager, and Human Resource Manager) monthly. Quality Assurance Committee will make recommendations to improve the process and determine when compliance has been reached.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure safety devices were in place for one resident (# 8) and failed to ensure adequate interventions where in place after a fall for one resident (#13) of twenty-two residents reviewed. The findings included: Resident # 8 was admitted to the facility on August 17, 2006, with diagnoses including Senile Dementia, Parkinson's, and Fractured Lumbar	F 323	**F 323 Free of Accidents Hazards/Supervision/Devices** **Corrective Action:** Alarm was replaced for Resident #8 on 3/13/10. Nursing staff was reeducated on alarm use by DON on 3/14/10. **Identification:** Current residents have potential to be affected. Current resident will have alarms reviewed for proper use and functioning by restorative nursing by 12/23/2010. **Systematic Changes:** Residents will have alarms reviewed for proper use and functioning daily by restorative nursing & weekly by ADON & Unit manager. **QA/Monitoring:** Director of Nursing will review the alarm audits and results of the review completed by restorative nursing, ADON, & Unit Manager with the Quality Assurance Committee (Administrator, Medical Director, Director of Nursing, Assistant Director if Nursing, Director of	12/23/10

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/06/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445498	A. BUILDING _____ B. WING _____	12/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRISTOL NURSING HOME	261 NORTH STREET BRISTOL, TN 37625

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 3 Vertebra. Medical record review of the current Care Plan revealed "...Problem...Risk for Falls d/t (due to) impaired mobility, hx (history) of falls...advanced Parkinson's disease...Approaches...assure that...seat belt alarm is in place for pt's (patients) safety..." Medical record review of a Nurse's Note dated March 13, 2010, revealed "...Summoned to room of resident...resident on floor...w/c (wheel chair) seat belt alarm not sounding alarm was turned to off...no noted injury..." Review of a fall investigation dated March 13, 2010, revealed the wheelchair seat belt alarm was not sounding due to the alarm was turned off. Interview on November 29, 2010, at 1:47 p.m., with Licensed Practical Nurse #2 (the nurse there at the time of the fall) in the facility conference room confirmed the alarm was turned off at the time of the fall on March 13, 2010. Interview on November 29, 2010, at 3:02 p.m., with the Director of Nursing in the Administrator's office confirmed the alarm was not turned on at the time of the fall. Resident #13 was admitted to the facility on January 21, 2010, with diagnoses including Alzheimer's Disease, Advanced Dementia with Behavioral Disturbance, and Parkinson's Disease. Medical record review of the current Care Plan dated February 3, 2010, revealed the resident exhibited wandering behavior related to cognitive	F 323	Social Services, Business Office Manager, Dietary Manager, Maintenance Director, Housekeeping Manager, and HumanResource Manager) monthly. Quality Assurance Committee will make recommendations to improve the process and determine when compliance has been reached. **Corrective Action:** Resident #13 was reviewed by social services & MDS Coordinator on 12/2/2010 for appropriate behavior management plan. IDT met with family of Resident #13 to discuss options in preventing injury to resident #13 related to wandering. Care Plan was updated to reflect new interventions by IDT on 12/2/2010. **Identification:** Current residents that wander have potential to be affected. Current resident with wandering behaviors will have care plans reviewed by IDT by 12/23/2010 to ensure adequate interventions are in place for safe wandering. **Systematic Changes:** IDT will review care plans & behavior management plans for resident with wandering behaviors monthly x 3 months, then quarterly to ensure interventions are in place and remain adequate to maintain a safe environment for wandering.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/06/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445498	A. BUILDING _____ B. WING _____	12/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRISTOL NURSING HOME	261 NORTH STREET BRISTOL, TN 37625

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 4 impairment. Review of a facility investigation dated July 25, 2010, revealed the resident had one non-injurious fall after being pushed in the dining room by a confused resident (#21). Continued review of the facility investigation dated July 25, 2010, revealed no intervention to address the resident's wandering. Review of a facility investigation dated September 15, 2010, revealed the resident had one fall after being pushed in the hall by a confused resident (#22), resulting in a cut over the resident's left eye requiring steri-strips. Continued review of the facility investigaiton revealed no intervention to address the resident's wandering behavior Observation on November 30, 2010, at 2:30 p.m., and on December 1, 2010, at 9:15 a.m., revealed the resident wandering in the hall opposite the resident's room location. Interview with the Director of Nursing (DON) on December 1, 2010, at 8:30 a.m., in the DON's office, confirmed the facility failed to develop additional interventions for this resident's wandering behavior to prevent further accidents.	F 323	QA/Monitoring: Director of Nursing will review the care plan review and results completed by IDT with the Quality Assurance Committee (Administrator, Medical Director, Director of Nursing, Assistant Director if Nursing, Director of Social Services, Business Office Manager, Dietary Manager, Maintenance Director, Housekeeping Manager, and Human Resource Manager) monthly. Quality Assurance Committee will make recommendations to improve the process and determine when compliance has been reached.	